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Testimony to the Little Hoover Commission: Topic: The Substance Abuse Treatment System in California

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I appreciate the opportunity today to provide an overview on the substance abuse treatment system in California. I will focus my remarks on how the current system evolved into its current configuration, some of the strengths of the systems, some of the weaknesses and needs of the system and efforts underway to improve the quality of treatment services and create systems of accountability between service providers and payer organizations. My perspective comes from almost 30 years of substance abuse work in California. After a decade of research on heroin addiction at UCLA, I spent 15 years founding and establishing a treatment organization in Southern California called Matrix Institute on Addiction and in 1996 I returned to UCLA to help direct the UCLA Integrated Substance Abuse Programs (ISAP), one of the largest addiction research, treatment and training groups in the US.

Background

The substance abuse treatment system in California has its roots in: 1. The Self-help Movement (AA, California Social Model and the Therapeutic Community Movement); 2. Medical Treatment (Methadone, LAAM, and other medications); 3. Community efforts to provide housing, medical care and social services to individuals with substance use disorders; and 4. Only recently, scientific knowledge. The fundamental elements of this system were all present and underway by the early 1970's. (Information is available in the attached Rawson and Obert article).

Self-help based treatments: The "pure" self help organization, Alcoholics Anonymous started in 1935 and by the early 1970s there were hundreds of AA chapters and meetings throughout California. Although AA is a completely voluntary self help organization and receives no public or private funding (donations are accepted from AA attendees), the principles and methods for achieving an alcohol free life were borrowed by both the California Social Model programs and the Therapeutic Community Movement.

The California Social Model includes a loosely affiliated group of organizations that provide housing, meals, social service support and fellowship to alcoholics in need of help. The "Model" developed out of the desire of alcoholics to help their fellow users who needed more than the support received by attending AA meetings. (During the first decades of this approach it focused on helping alcoholics and had minimal involvement of those addicted to drugs. This has changed in the past decade). The "treatment" provided within these programs was completely focused on the indoctrination of "clients" with the 12 step philosophy of Alcoholics Anonymous. Medical services were typically not provided as alcoholism and addiction were viewed as "diseases of the spirit", rather

than a biological disorder. These programs were/are staffed exclusively by recovering addicts and alcoholics, who had little if any formal education in alcoholism or addiction. In fact, there was/is a fundamental skepticism about the value of professional training among proponents of this model. The belief is often expressed "if you haven't been there (alcoholic or addict), you can't know what its like and you really can't help a person to recovery". There is an intensely held belief that the role of "treatment" is to show the addict/alcoholic the path to recovery by personal example and fellowship in AA. "Book learning" was/is viewed as irrelevant. Historically, these programs have been resistant to evaluation and data collection since they have been loosely structured and have generally not employed systematic evaluation procedures for either treatment outcomes or program performance. The model is strongly dependent upon the belief that 12 step-based recovery is the only way to get sober and all other approaches are erroneous.

While the California Social Model adapted 12 step principles and techniques to helping alcoholics, the same set of principles were adopted by a group of drug addicted individuals living in Santa Monica, who, in 1957, formed the first "therapeutic community", known as Synanon. Treatment in these therapeutic communities (TCs), consisted of a very structured residential living regimens , requiring abstinence from drugs and alcohol and removal from society for long periods (typically 1 to 2 years prior to 1990, more recently, 6-12 months). In the TC living facility, all residents are addicts all treatment is provided by more senior members of the community who have achieved longer periods of abstinence. As with the California Social Model, TC depend upon addicts helping addicts. Therapy group sessions often involved confrontational and often verbally aggressive approaches. TCs rapidly expanded in California and became the basic paradigm for residential treatment of addiction by the 1970s. There has been considerable research conducted on TCs, showing good efficacy for those individuals who are retained in the programs for the prescribed treatment durations. However, many studies have reported very high attrition rates, with drop out rates in the first 30 days frequently exceeding 80%. While TCs initially resisted the intrusion of professional health care staffing, in recent years, there has been an increasing trend for TCs to have medical and psychiatric services available when needed. However, fundamentally the approach is still highly focused on the use of recovering addict staffing and addicts serving as role models for their peers. This form of treatment is the most popular treatment approach among criminal justice personnel and the most widely applied approach in criminal justice settings (eg prisons).

Methadone: Medical practioners have long been involved in the treatment of substance use disorders. Until the emergence of methadone in the 1960s, the role of medical treatment and medications was limited to treatment of withdrawal from alcohol and other addictive drugs. The research of Dole and Nyswander in New York City in the 1960s demonstrated the efficacy of methadone maintenance as a long term modality for allowing heroin users to remain in treatment while on methadone for an unlimited period. Methadone maintenance treatment was introduced into California in 1971 as part of the "war on drugs" during the Nixon administration. Since that time, clinics that dispense methadone (Narcotic Treatment Programs-NTPs) have been introduced into over 30 counties in California and currently over 20,000 individuals are in treatment receiving

daily doses of methadone, along with the ancillary medical and counseling services. Although a second medication, Levo-alpha-acetylmethadol (LAAM) was approved for use in this setting in 1995, its use has been minimal and the large majority of patients in treatment in NTPs are taking methadone.

Although the research literature supporting the efficacy and value methadone is overwhelming in reducing heroin use, the crime associated with heroin use and reducing the transmission of HIV and hepatitis, it is still the most misunderstood and under appreciated addiction treatment. Many of the supporters of other treatments have been among the biggest critics of methadone maintenance. For many proponents of treatments advocating total abstinence from all drugs and medications, the use of methadone is viewed "not true recovery" and "simply substituting one drug for another". Similarly, methadone is still extremely unpopular among many members of the law enforcement community and with many if not most judges. Although the approval of the new heroin addiction medication buprenorphine/naloxone will greatly expand medication treatment later this year, at present the status of medication treatment (methadone) for addiction treatment is widely used, but still very controversial.

Community service development: Throughout the past 30 years communities have attempted to develop a broad range of community-based services for substance abuse disorders. These have included hospital-based inpatient units for detoxification, residential 28-day rehabilitation programs (Minnesota Model), residential dual diagnosis programs associated with mental health and psychiatric organizations, and residential specialty treatment organizations for women and adolescents and other special populations. In general, these programs combine a mix of 12-step program activities and professional counseling. The specific elements (type of therapy, staffing qualifications of staff, duration of stay, etc.) of these programs are quite variable.

Outpatient treatments emphasizing abstinence evolved during the 1980s as cost containment. Even more variability is found in the content, structure, duration, staffing, etc. of the wide variety of these programs. Very few standards have been developed to provide guidelines for these programs. At present, these are the most widely used and have the most poorly established treatment efficacy.

Introduction of Science to Treatment: The application of empirically-supported treatment approaches (those with solid scientific support) to real world treatment programs has recently become a increased priority. Federal initiatives from NIDA and CSAT are promoting the use of these scientifically supported approaches. In California, these initiatives are quite extensive and are attempting to substantially influence the delivery of care. There are many obstacles to the successful modification of existing treatment with science, however, efforts to close the gap between research and treatment are showing some progress.

Strengths of the Substance Abuse Treatment System in California

The California substance abuse treatment system has numerous strengths:

1. Treatment for substance abuse disorders in one form or another is distributed throughout California.
2. There is a diversity of treatment approaches in California and in most urban areas, it is possible to find most of the major treatment program types.
3. There is a dedicated workforce that is committed to helping individuals with drug and alcohol problems.
4. Through the efforts of the California Society of Addiction Medicine (CSAM), the expertise of physicians who treat patients with drug and alcohol problems have been tremendously improved over the past decade.
5. Efforts to move scientifically-supported approaches into application are making progress to moving into the "real world".
6. The "connection" between the California treatment system and the scientific community (primarily the UC system) is stronger in California than any where else in the US.
7. The current leadership of the California Department of Alcohol Programs is the strongest and most forward thinking leadership in the past 30 years.
8. The development of cooperative relationships between the substance abuse treatment and the criminal justice systems has rapidly and positively occurred as a result of the drug court movement and Proposition 36.
9. Substance abuse treatment in California prisons has dramatically expanded in the past decade.
10. Proposition 36 is the most important innovation in promoting substance abuse care in the past decade.
11. Some of the treatment programs in California are used as models for how to deliver treatment in the US and around the world and probably deliver the best treatment available anywhere in the world.

Weaknesses and Needs of the California Treatment System

1. The foundation of much of the current substance treatment in California is based on tradition and personal ideology. There is little system in place for determining which treatment programs are delivering effective care from those who deliver ineffective care.
2. The funding of treatment is not in any way connected to treatment effectiveness or the use of effective methods.
3. Many of the treatment programs who claim to be delivering treatments with empirical support, attempt to do so with staff who are inadequately qualified, patient case loads that are completely unrealistic and with entirely inadequate support services. Many of these programs that deliver established treatments (eg methadone, TC, prison treatment) may be implementing these treatment so poorly that they do not produce the same beneficial outcomes that have been shown to occur with properly delivered care.
4. There is no system in place in California to license treatment programs (except NTPs) or to license or certify counselors. Meaningful educational requirements for counseling staff are almost completely nonexistent.

5. There is no meaningful evaluation system for determining the quality or effectiveness of treatment services in California.
6. Training opportunities for substance abuse treatment staff are very minimal and the quality and content of these existing training activities is questionable.
7. There is no system in place in California to match the needs of patients/clients with the most appropriate level of type of care.
8. In some areas of California, there is not a full range of service options available and in much of California there is not a sufficient treatment capacity.
9. Treatment for adolescent substance abusers and individuals with co-ocuring psychiatric disorders are particularly lacking in capacity or in treatment models with empirical support.
10. Funding for substance abuse treatment services has historically been very erratic and uncertain. The increased funding provided by Prop 36 may be offset by budget cuts currently under consideration.

Activities to improve the quality/accountability of SA services in California

1. Efforts are underway to develop a minimum set of credentials for counselors for required licensing/certification.
2. Organizations including Joint Commission for Accrediting Healthcare Organizations (JCAHO) and the Commission to Accredit Rehabilitation Facilities (CARF) are becoming more widely recognized in California as ensuring quality care.
3. Treatment evaluation programs systems have been devised for statewide service evaluation (CALTOPPS), funding is currently under consideration. A similar system in LA County (LACES) for evaluating the entire county system is currently being implemented.
4. The recent award of the CSAT Addiction Technology Transfer Center (ATTC) to UCLA will result in much expanded SA training in California.

There are clearly many areas in which the California leads the US in its substance abuse service delivery. At the same time, there are many areas in which the service delivery system can be improved and made more accountable.

I hope my information is of use to the Commission.

Respectfully submitted.

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